ALCOHOLISM & DRUG ABUSE WEEKLY
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In This Issue...

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Treatment centers: 12-step and MAT should coexist

The polarization of the treatment field between medication-assisted treatment (MAT) and 12-step drug-free treatment is gradually dissolving, according to experts interviewed by *ADAW* last week. "The problem is that some people view it as either/or," said Philip L. Herschman, Ph.D., chief clinical officer of CRC Health Group. "Either it's MAT and nothing else, or it's 12-step and nothing else."

At many treatment programs, including CRC and the Hazelden Betty Ford Foundation (the nation's largest for-profit and not-for-profit treatment chains), it's not either/or — it's both. And the National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports both as well.

Bottom Line...
Medication-assisted treatment and 12-step philosophy should be integrated in addiction treatment, according to two of the country's biggest treatment providers.

Buprenorphine, methadone and Vivitrol are all proven medications that work, but not necessarily with the same patient, said Herschman. But other psychosocial treatments are necessary as well, including cognitive behavioral therapy (CBT).

"There are multiple evidence-based treatments, MAT being just

See Coexistence page 2

The Business of Treatment

Providers can challenge insurance without compromising collegiality

B$T

For addiction treatment facilities just entering the private insurance market, an organization such as Gosnold on Cape Cod can serve as a useful example of how to build lasting working relationships with insurance payers. The Massachusetts organization signed its first managed care agreement 30 years ago, and its share of revenues from private insurance sources now stands at 45 percent.

Gosnold's president and CEO, Raymond V. Tamasi, told *ADAW* that achieving success in the insurance market often hinges less on the "how" of the language of conversations (see *ADAW*, Feb. 17) and more on the "who" of the staff member having those discussions with insurance representatives.

Bottom Line...
The president and CEO of Gosnold on Cape Cod believes that the quality of the working relationship between his staff members and private insurers' reviewers often proves to be the greatest determinant of success in working in the insurance market.

"We do try to line up our [utilization review] people with particular insurers," said Tamasi. While this does not mean an insurance review-

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one of them," said Marvin Seppala, M.D., chief medical officer of the Hazelden Betty Ford Foundation. But MAT is an important one, especially because of the high overdose rate for opioid addiction. "If you neglect the literature and the science of addiction, you still have to look at the death rate," he said. Hazelden added buprenorphine because so many patients overdosed after being discharged from treatment there (see *ADAW*, November 12, 2012).

"We try to differentiate between three different groups" for patients with opioid addiction, said Seppala — one treated with naltrexone (Vivitrol), one with buprenorphine and one drug-free.

The medications for alcoholism aren't as good, and there are no medications for other drugs of abuse, noted Seppala.

Role of AA

"Hazelden is founded on the use of the 12 steps; it is one of the absolute tenets of treatment here," said Seppala. "We are going to continue to emphasize the use of AA, CA and NA."

Interestingly, Hazelden is "having really good outcomes on the people who refused medications but who stick around in our psychosocial therapy," said Seppala. "And the people on the medications are doing well."

Physicians can't predict who should be on medication and who shouldn't, or who should be on what medication, said Seppala. "We're trying to walk down the middle. What do you do with a 19-year-old who just started on oxycodone six months ago?" he asked.

But regardless of age, every patient who comes into a program should be informed that medications exist and may help, said Seppala. "I'm a psychiatrist and I was trained to give information — on what might work and on the risks," he said.

There is adequate evidence to support the use of 12-step programs for people with addiction, said Seppala. Some critics claim that 12-step does not include a "manual" that has been proven by clinical trials (with the impossible placebo group) to work.

But even with CBT, the best therapists do not stick to a "manual," said Seppala. "An experienced psychotherapist may have been trained according to a distinct model, but over time they realize it doesn't work for everyone, and they alter their practice for different patients," he said.

A good addiction treatment program should have a training system that helps their clinicians have a foundation in evidence-based practice, said Seppala. "But to say 'We're going to use CBT and you have to do it with a manual' — that's nonsensical," he said.

CBT alone isn't adequate, and 12-step alone isn't adequate, said Seppala. "It's true that I can suggest that people go to 90 meetings in 90 days, and some of them will stay sober," he said. "But we need to individualize treatment."

Hazelden has a "stigma management" program to help patients who are on buprenorphine, because there is such a lack of understanding of MAT.

Alcoholics Anonymous and similar 12-step groups are "supports as part of a complete treatment plan for recovery," said CRC's Herschman. As a support system, AA is part of the treatment "that happens after an acute episode of treatment," he said. "But in and of itself, AA is not treatment."

'Sobriety' first

But David Lisonbee, president and CEO of Twin Town Treatment Centers in Los Alamitos, California, thinks that some programs are too reliant on pharmaceuticals. "We as treatment providers have allied with our clients and the interests of our clients, and our preferences and our goals have to do with long-term recovery and sobriety, which in the

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classic terms means you're coping with a minimum of assistance," he said. Some people, he said, feel that the profit motive is behind the designation of buprenorphine as a maintenance medication instead of a detoxification agent (it can be used as either).

Many providers now accept that for some patients — the long-term heroin addict, for example — maintenance medication is appropriate, said Lisonbee. "Where we balk at maintenance is if it's an occasional user or a young adult who has dipped into his parent's medicine cabinet," he said. "That person is suited to long-term sobriety."

But, he acknowledged, the field is changing. "The field used to balk at antidepressants, but over the past 10 to 15 years antidepressants have been a treatment of choice when there's a coexisting affective disorder," said Lisonbee.

Evidence base for AA

There is evidence for the effectiveness of 12-step facilitation (AA) in Project MATCH, the NIAAA-funded comparison of CBT, motivational enhancement therapy and AA. That study concluded in 2001 but has been used for other studies showing the evidence of the effectiveness of AA (see *ADAW*, June 17, 2014).

"Excessive drinking is a heterogeneous disorder," said Raye Z. Litten, Ph.D., associate director of the NIAAA Division of Treatment and Recovery Research. "That's why one philosophy doesn't work for everyone — but we think AA can work for some people."

More studies have been done recently on AA, said Litten. "People do attend [AA], they stick with it, and they have improvements in drinking outcomes."

> **'People do attend [AA], they stick with it, and they have improvements in drinking outcomes.'**
>
> Raye Litten, Ph.D.

"I'm happy to hear that they're putting more of a menu of treatments" in addiction treatment centers, said Litten, referring to MAT. "If one medication doesn't work, another one might."

Litten recalled that last year at the ASAM annual meeting there was a special symposium on integrating AA and 12-step recovery into treatment. "There's more going on here than meets the eye," he told *ADAW*. "Some people have worked hard and found medication works in some people, and they are frustrated that more people aren't using it," said Litten. "But that doesn't mean you should bash AA." There are more than 50,000 AA groups in the United States, noted Litten. "Where else can you go for help that's free and confidential?" Litten said.

Litten noted there is a stark difference between methadone and buprenorphine, the agonists used to treat opioid addiction, and acamprosate and naltrexone, which are medications approved to treat alcoholism. "Everyone who gets methadone or buprenorphine will have an effect from those medications," said Litten. "But the alcohol medications don't work for everyone."

Still, it's important to have the full toolbox to offer to patients. And Lisonbee agreed. "We are getting there," said Lisonbee. "But we don't want our treatment providers to be in it for the profit. We don't want people to submit to a treatment industry that makes more dollars. We want to be client advocates." •

Urine test fraud results in fine for Kentucky bupe clinics

SelfRefind, a chain of buprenorphine treatment providers based in Harrodsburg, Kentucky, has agreed to pay $1 million to the federal government to resolve allegations of fraudulently billing Medicare and Medicaid for medically unnecessary and excessive urine tests, the U.S. Attorney's Office for the Eastern District of Kentucky announced February 10. The fine is part of a much larger settlement involving the two physician owners of SelfRefind, Bryan Wood and Robin Peavler, and the laboratory that billed for the fraudulent tests, PremierTox.

Under the $15.75 million agreement, Wood and Peavler will also pay $1 million each, and PremierTox will pay the remaining $12,750,000 plus interest over a period of five years.

Medicaid and managed care companies that administer Medicaid have suspended payments to SelfRefind, according to the settlement agreement. (However, SelfRefind does not bill Medicaid; it is self-pay.)

Unnecessary tests

SelfRefind, the two physicians and the laboratory violated the False Claims Act by submitting claims that were not necessary — they conducted tests on old, frozen urine samples and billed for the tests, even though results were of no use in patient care, according to the settlement agreement, signed by SelfRefind (also known as Addixxion Recovery of Kentucky), Wood and Peavler, and PremierTox.

"Federal health care programs are essential to many of our citizens," said U.S. Attorney Kerry B. Harvey. "We will not tolerate efforts by misguided providers to unfairly enrich themselves at the expense of these programs and the taxpaying public. This settlement underscores

Continues on next page

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the continuing commitment of our office to use every available tool to protect these vital programs from false claims."

"Billing Medicare and Medicaid for laboratory tests that are not necessary contributes to the soaring costs of health care," said Assistant Attorney General for the Civil Division Stuart F. Delery. "Providers will be aggressively investigated and held accountable for falsely billing federal health care programs."

Kentucky will receive about $2.74 million, representing the state's share of Medicaid funds recovered.

"Substance abuse is devastating our Commonwealth, and addiction is ripping families apart," Kentucky Attorney General Jack Conway said. "Treatment centers and their owners should be focused on patient care rather than profits. Companies that take advantage of Kentucky's Medicaid program will not be tolerated, and I am pleased that we were able to recover this money for such a vital state program and for Kentucky taxpayers."

The investigation was conducted by the Kentucky Office of the Attorney General, Medicaid Fraud and Abuse Control Unit, Kentucky State Police and U.S. Attorney's Office.

Unnecessary tests

SelfRefind has clinics in 12 Kentucky cities and requires all patients to submit to regular urine screening. In December 2010, Wood and Peavler became owners of PremierTox, and they began to "automatically" refer all SelfRefind drug screens to PremierTox for confirmation tests, according to the settlement agreement. Before the physicians became part owners of PremierTox, they did not have any automatic confirmation testing done.

However, PremierTox did not have the necessary equipment to conduct confirmation tests when the samples were first sent by SelfRefind. So for eight months, the lab froze the samples in a storage unit before performing the tests, which by that point were not necessary for the treatment of the patients. Nevertheless, the lab submitted claims for reimbursement.

As part of the settlement, PremierTox has entered into a Corporate Integrity Agreement with the federal Department of Health and Human Services to undertake internal reforms and submit to a third-party review of its claims to Medicare and Medicaid for the next five years. SelfRefind is no longer doing business with PremierTox.

"We are moving forward with our new ownership and eLabs, and as always our goal is to provide a safe environment that provides support and treatment to those seeking recovery from their addiction.'

Michele Flowers McCarthy

SelfRefind responds

Treatment at SelfRefind is self-pay, but the urine tests are paid for by Medicaid. "Drug testing is one of the services we require as part of our programming, but we do not provide it ourselves — it is a contracted service," said Michele Flowers McCarthy, community and government liaison for SelfRefind. The billing is done by the drug-testing laboratory, she told *ADAW*. The buprenorphine itself, however, is covered, and many payors require drug testing as part of the prior authorization, according to McCarthy. "We view drug testing as an essential part of treatment, as it is the only means we really have to be able to confirm whether a patient is taking the medication we prescribe and not using other substances," she said. "This helps us address compliance as well as patient safety, and progress in treatment and recovery."

SelfRefind tests for all major drug categories as well as buprenorphine, said McCarthy. Confirmation testing is often necessary because, for example, the "quick cup–type tests cannot tell you what benzodiazepine a patient is positive for, and may not even register some of them," she said. "Since we need to be able to make appropriate clinical and medical decisions and we are talking about people's recovery and lives, it is essential for us to have as clear a picture as possible as to what may be going on."

The investigation has been "an opportunity to review our protocols and paperwork, as there is always room for improvement," she said. "We support the work of the DOJ and the Attorney General — it is their duty to ensure public safety and we appreciate their ongoing effort to scrutinize health care providers who provide care to our citizens." The investigation has not caused any "disruption in patient care," she said.

"We are moving forward with our new ownership and eLabs, and as always our goal is to provide a safe environment that provides support and treatment to those seeking recovery from their addiction," said McCarthy. •

For the settlement agreement, go to www.justice.gov/usao/kye/news/2014/PremierTox.pdf.

ASAM issues safe methadone induction guide, noting OD risks

A who's who of methadone maintenance treatment experts, gathered together by the American Society of Addiction Medicine (ASAM), has produced guidelines on safe methadone induction and stabilization, focusing on overdose prevention. The ASAM Methadone Action Group conducted a literature review and published its opinion in the November/December 2013 issue of the *Journal of Addiction Medicine*, the official journal of ASAM.

"The use of methadone to treat addiction has saved countless lives in the last 50 years, but it also has an increased risk of toxicity and adverse events for the patient during the medication's induction and stabilization phases," said Louis Baxter, M.D., ASAM immediate past-president, chair of the expert panel and lead author. "The protocols designed by the ASAM expert panel could dramatically decrease these negative outcomes if all clinicians prescribing methadone would follow them."

According to the ASAM press release announcing the expert opinion, released January 22, overdoses "associated with methadone usually occur through accumulated toxicity caused by overly aggressive induction and through patients who combined their prescribed methadone with other opioids, sedatives or alcohol." Deaths are more likely to occur during the first two weeks of treatment because the patient is using other drugs, or because the provider overestimates the patient's tolerance to methadone, according to ASAM.

Overdose deaths in patients who are in opioid treatment programs usually occur during the induction and stabilization phases. Because of this, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) invited ASAM to convene the expert panel.

The panel evaluated the literature and collaborated in formulating the consensus statement.

Family education

The panel recommended that for the first two weeks of treatment — the induction phase — the family and patient should be educated about the effects of methadone. For example, patients should think about how they feel during the peak effects, and not the trough, which occurs about 24 hours after medication is taken, just before the next dose. Otherwise, the report noted, patients will think they are in withdrawal and need a higher dose, instead of waiting for the medication to accumulate in the body. Dosing should be done in the morning, as overdose is most likely to occur at night when someone is asleep and symptoms may not be noticed. Family members must also be educated about the signs of overdose.

Patients should be cautioned against trying to relieve withdrawal symptoms with methadone, other opioids, benzodiazepines or alcohol, all central nervous system depressants that could contribute to overdose when combined.

Dosing

Many patients may feel as if they are in withdrawal, and it may take days or weeks for the body to adjust to the dose, because methadone accumulates.

In terms of dosing, the dictum "start low, go slow" is followed by the ASAM panel.

The initial dose is typically 10 to 30 milligrams a day, according to the panel. If this is not sufficient to relieve withdrawal symptoms, the patient should be asked to wait for reassessment in two to four hours, when the peak levels are achieved. If withdrawal symptoms continue or reappear, an additional 5 to 10 milligrams may be provided, with the total dose on the first day not exceeding 40 milligrams.

The first day's dose should go up every five or more days by 5 milligrams or less.

During weeks three and four — early stabilization — optimal dosing should be reached. Optimal dosing is defined by the panel as no withdrawal symptoms for 24 hours, no drug hunger or craving, a tolerance to the sedative effects, and a blockade of euphoric effects if the patient self-administers opioids. •

'The use of methadone to treat addiction has saved countless lives in the last 50 years, but it also has an increased risk of toxicity and adverse events for the patient during the medication's induction and stabilization phases.'

Louis Baxter, M.D.

For the report, including the list of authors, go to www.asam.org/docs/default-source/publicy-policy-statements/safe_methadone_induction_and_stabilization__report-1.pdf?sfvrsn=2.

Study: Topiramate helps some heavy drinkers cut back

Researchers at Penn Medicine have found that topiramate reduces drinking in patients who want to cut back. According to the findings, published online in the current issue of the *American Journal of Psychiatry*, topiramate is particularly effective among patients with a certain genetic predisposition.

"This study represents an important next step in understanding and treating problem drinking," says Henry R. Kranzler, M.D., professor of psychiatry at the Perelman School of Medicine, where he is director of Penn's Center for Studies of Addiction at the University of Pennsylvania. "Our study is the first we are aware of in which topiramate was evaluated as a treatment option for patients who want to limit their drinking to safe levels, rather than stop drinking altogether," said Kranzler, who is lead author. Heavy drinkers may not seek treatment, but if they want to cut down, they may find that difficult on their own.

For this study, 138 heavy drinkers received either 12 weeks of topiramate or 12 weeks of placebo. Both groups had brief counseling to reduce drinking. At the end of the 12 weeks, there was a nine-day medication taper.

The patients who took topiramate had fewer heavy drinking days than patients in the placebo group; at the end of the 12 weeks, patients in the placebo group were five times more likely to have a heavy drinking day than patients in the topiramate group. During the last four weeks of treatment, there were twice as many patients in the topiramate group who had no heavy drinking days compared to patients in the placebo group. Finally, patients in the topiramate group had more abstinent days than patients in the placebo group. Researchers interviewed subjects every week about alcohol consumption.

Specific genotype

The study found that the only people who benefited from topiramate were those with a specific genotype, found in 40 percent of European-Americans. The study found that individuals with a certain form of the glutamate receptor were able to reduce drinking.

'These findings may allow us to predict, in advance, who may benefit from topiramate treatment, thereby avoiding the unnecessary use of the medication.'

Henry R. Kranzler, M.D.

The study helps narrow down the types of medications that are needed to reduce heavy drinking, according to authors. While topiramate affects multiple neurotransmitter systems, the genetic information shows that by targeting the glutamate receptor, the maximum therapeutic effect in heavy drinkers could be reached. Topiramate's common side effects, including fatigue, dizziness and memory problems, could also be reduced by a narrow focus on that receptor. "These findings may allow us to predict, in advance, who may benefit from topiramate treatment, thereby avoiding the unnecessary use of the medication," said Kranzler.

Many alcoholism researchers have begun focusing on "personalized treatment," because it has become clear that some medications work for some people, but not everyone. In the case of heavy drinkers who want to cut down — and thus reduce many of the adverse health effects of alcohol consumption — Kranzler said topiramate offers help. "Our hope is that the study will result in additional research on how best to help patients who have struggled with heavy drinking and the problems it causes, but who are unable or unwilling to abstain from alcohol altogether," he said.

A seminal study by Bankole Johnson, M.D., Ph.D., and colleagues published in the *Archives of Internal Medicine* found that topiramate improves physical health and quality of life for people with alcoholism (see *ADAW*, June 16, 2008).

Topiramate (Topamax) is approved by the Food and Drug Administration for the treatment of epilepsy.

The Kranzler study was supported by the National Institute on Alcohol Abuse and Alcoholism. •

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er is guaranteed to speak with the same person at Gosnold at each contact, it does help in the effort at relationship-building that the provider sees as critical in working with a number of private payers.

And building those relationships allows Gosnold to offer sufficient representation of patients who are unable to represent themselves at a time when they are felled by illness — and this representation often will include actively challenging insurance decisions that do not appear to coordinate with the payer's own published criteria.

"We challenge when we feel there's a reasonable case," Tamasi said. "If our clinical staff advises that the patient really needs additional time, it is our job to provide a convincing case, and we will go to the downs with it."

Building trust

Tamasi said, "The most important thing to recognize is you don't want to put yourself in the position of being an adversary to a managed care organization." Gosnold approached its first managed care company more than a generation ago with the message that it could provide effective care at a reasonable rate, "and that got us on the map," he said.

Communication with insurers tends to be more open today than in the past, Tamasi suggested, especially since the companies' criteria for reimbursement are now easily accessible to providers and the public. Still, he said, providers can run into problems when the questions that arise from insurance representatives appear to stray from the payer's own criteria.

And while providers have to expect some variations in procedure from insurer to insurer, they also will experience differences in interpretation from reviewer to reviewer within the same company. "One reviewer might look at a case and say that a stay of an additional four or five days can be justified, and another reviewer could look at the same case and say treatment can be done in an ambulatory setting," Tamasi said.

These discrepancies also can be caused, however, by inconsistencies that crop up at the provider's end. "Some of our folks might be more skilled in communicating than others," Tamasi said. "Or the documentation might be better from some clinicians in the organization than others."

Still, the quality of the personal relationship that is built between the provider representative and the insurance reviewer might make the biggest difference. "There has to be some sense of trust and mutual respect," Tamasi said. "Then it becomes easier to have a conversation about what the patient might need."

He added that it is important to enter into conversations with insurers with the mind-set that the two entities are partners. Treatment facilities must realize that the managed care organization may often think in ways that will actually help inform the care that the provider delivers, he said.

However, Gosnold will not hesitate to challenge a denial of care when the evidence basis on its end appears strong. The appeals process can be laborious, Tamasi said, with multiple steps and doctor-to-doctor reviews, but the effort can prove valuable to the provider and the patient without compromising the long-term relationship with the insurer, he believes.

"If our providers can present a cogent argument, we do pretty well [with appeals]," he said.

'There has to be some sense of trust and mutual respect. Then it becomes easier to have a conversation about what the patient might need.'

Raymond V. Tamasi

Downward pressures continue

Tamasi said he largely sees a continuing pattern of tightening of insurance restrictions on various levels of care. Gosnold, which also receives about 25 percent of its revenue from public funds and about 30 percent from self-pay, works with a handful of dominant insurance carriers, a few smaller players in the region's market, and managed Medicaid plans.

"The pressure on inpatient stays is unrelenting," Tamasi said.

A prominent offshoot of this involves some insurers' reluctance to authorize inpatient detoxification stays for opioid-dependent patients. "Some will say, 'Send the patient to ambulatory detox,'" Tamasi said. "But there are so many other factors involved for these patients that this often can only be done successfully in inpatient detox."

He added that it also has become important for providers to do a better job of educating families about what their insurance benefits entail. "Many policies are written to say that the person is entitled to 30 days of care, but we have to remind families that this is based on medical necessity," he said. "And of course, families think what they're pursuing is absolutely medically necessary."

Tamasi concluded that if providers look at their relationship with insurers as a partnership and not as adversarial, and if they take the time to understand the full implications of the contracts they sign, they can achieve success.

"It's possible to do business with managed care organizations and enable your organization to thrive," he said. "You've just got to go in with your eyes open." •

Briefly Noted

Another delay in Obamacare means fewer covered patients

The latest major delay of the rollout of the Affordable Care Act affects employers with 50 to 99 full-time workers, who won't have to comply until 2016, the Obama administration announced February 10. And larger companies only have to cover 70 percent of full-time workers. The delay was in response to employer pressure: some firms had

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cut back employees' hours so that they didn't have to pay a fine for not covering workers. Originally, the Affordable Care Act required employers with the equivalent of 50 or more full-time workers to offer insurance coverage or pay a fine, starting in 2014. That requirement was put off to 2015 last year. The delays may be disappointing to health care providers, who had hoped for increased insurance coverage to increase the number of treated patients.

Coming up...

NAADAC, the Association for Addiction Professionals will holds its annual advocacy conference **March 2–4** in **Alexandria, Virginia**. For more information, go to **http://naadac.org/advocacyconference**.

The 45th annual medical-scientific conference of the **American Society of Addiction Medicine** will be held **April 10–13** in **Orlando**. For more information, go to **www.asam.org/education/annual-medical-scientific-conference**.

The **2014 National Rx Drug Abuse Summit** will be held **April 22–24** in **Atlanta**. Go to **http://nationalrxdrugabusesummit.org/event** for more information.

The **National Council for Behavioral Health** will hold its annual conference **May 5–7** in **Washington, D.C.** For more information, go to **www.thenationalcouncil.org/events-and-training/conference**.

In the States

West Virginia justice reinvestment to move offenders into treatment

Nine West Virginia counties are poised to implement a justice reinvestment program in which money from the criminal justice system is directed at treatment for substance use disorders (SUDs). The pilot program will offer community-based treatment to people on probation, parole and supervised released, the *Register-Herald* reported February 17. The program, directed by the West Virginia Department of Military Affairs and Public Safety, is a "major step" in the right direction, according to state legislator John Shott. "Basically it is intended to provide courts and judges with additional options to help treat people that need help," he said. By treating offenders who are at high risk for re-offending, the effort will decrease recidivism and incarceration. "This will be a coordinated effort between the court system and other programs that work with substance abuse," Shott said. Southern Highlands Community Mental Health Center, based in Princeton, is one treatment program that will be applying for funding, said director Judy Akers. "We want to do all the substance abuse treatment that we can," Akers said. Justice reinvestment "puts West Virginia on a path to address one of the biggest issues driving prison growth — substance abuse," said Department of Military Affairs and Public Safety Cabinet Secretary Joseph Thornton. "Simply locking offenders up without offering effective rehabilitation services during incarceration, or in the community upon release, simply ignores the problem." Last summer, Attorney General Eric Holder called for reducing the federal prison population and placing people who need SUD services in treatment instead (see *ADAW*, August 19, 2013).

Alcoholism & Drug Abuse Weekly welcomes letters to the editor from its readers on any topic in the addiction field. Letters no longer than 350 words should be submitted to:

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Letters may be edited for space or style.

Call for Nominations

National Council for Behavioral Health seeks Board Nominations

The National Council for Behavioral Health invites nominations from behavioral health organizations for seven open seats on its Board of Directors. Nominees for each region must be from the leadership or boards of National Council member organizations in those regions. There are 20 directors on the Board of Directors, two from each of ten regions. Directors are expected to represent their entire region on the National Council board as well as to be active in issues affecting behavioral health on a national level. The call for nominations is open until March 18. To nominate someone, contact Kara Sweeney: KaraS@thenationalcouncil.org, (202)684-7457.

In case you haven't heard...

The police manhunt in New York City for the dealer who sold Philip Seymour Hoffman the heroin that killed him has, not surprisingly, turned up a heroin addict in its investigation. A musician arrested for possession of heroin said that his own addiction was the reason he sold drugs, *The Associated Press* reported February 18. His lawyer has asked that his case be transferred to a drug court, so that he can get treatment instead of going to prison. The musician was a friend of Hoffman's but denied providing him the heroin that killed him. Many heroin "dealers" are themselves addicts who are supporting their habit by selling, and who need treatment.